PROVIDER BULLETIN

JUNE 2011 Fourth Edition, Issue 5 Network Providers

A Publication of the Local Mental Health Plan of the County of Los Angeles Department of Mental Health

IN THIS ISSUE

MEDICARE CERTIFICATION

State California Department of Mental Health (DMH) Information Notice No.: 11-04 dated February 17, 2011, provides policy guidance regarding county mental health plan claiming for Medi-Cal reimbursement for specialty mental health services provided to beneficiaries eligible for both Medicare and Medi-Cal (dual eligibles).

It is **mandatory** for all Fee-For-Service Network Providers, with the exception of Marriage-Family Therapists (MFTs), to be certified with Medicare. A provider subject to Medicare certification but is **not** Medicare certified must apply to Medicare for certification.

A contract provider who is certified by Medicare and renders services at a place of service eligible for reimbursement under the Medicare Program, must claim Medicare for services prior to claiming Medi-Cal except as described in DMH Information Notices 09-09, 10-11, and 10-23.

CHANGE IN CREDENTIALING RENEWAL PERIOD

In order to provide specialty mental health services to Los Angeles County Medi-Cal beneficiaries, providers must be credentialed and contracted with the County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP).

The credentialing period has been changed from two to three years. Effective upon your next re-credential, the cycle will be every three years.

LOCAL MENTAL HEALTH PLAN
OFFICE OF THE MEDICAL DIRECTOR
MEDI-CAL PROFESSIONAL SERVICES & AUTHORIZATION DIVISION
550 S. Vermont Ave, 7th Floor, Los Angeles, CA 90020
Phone: (213) 738-3311
Fax: (213) 351-2024
Website: http://dmh.lacounty.info

ADDITION OR DELETION OF GROUP MEMBERS

Attention: Group Providers

In order to ensure that our records are accurate on an on-going basis, beginning immediately, group providers will be required to notify the Provider Credentialing Unit of the date that a rendering provider terminates from the group. Attached to this bulletin, you will find the Group Network Provider Application Form (Attachments A & B) that can be faxed or mailed to the unit.

Department of Mental Health
Provider Credentialing Unit
550 South Vermont Avenue, Room 703A
Los Angeles, CA 90020
Fax: (213) 351-2495

If you have any questions or need additional information, please contact the Provider Credentialing Unit at (213) 738-2814.

CLAIM SUBMISSION GUIDELINES

It is the responsibility of each provider to submit claims for services rendered in a timely manner.

Claims must be electronically submitted to the LMHP to be processed, approved, converted to a SD/MC claim format and then transmitted to the State Department of Health Care Services (DHCS) for adjudication. Claims that do not reach the LMHP in time to be processed, approved, transmitted and received by the DHCS within six months from the date of service will not be considered timely, and will be denied by the DHCS. A Valid HIPAA Delay Reason Code [Late Code] must be entered on claims that are not received by the DHCS by the six months limitation but are under the one year limit to be accepted for adjudication in the Integrated System.

LMHP recommends providers submit claims weekly, and promptly review, correct and resubmit any denied electronic claims that are eligible for correction.

Please note: Claims may take 6-8 weeks to process from the date of claim submission to the LMHP before reaching the DHCS. Delays in claim submission will severely limit the time remaining to correct and resubmit denied electronic claims.

CONTRACT COMPLIANCE – CHANGE OF CONTACT INFORMATION

According to your Agreement with the County of Los Angeles, Department of Mental Health (DMH), Fee-For-Service Network providers must initiate and provide written notification of any changes to contact information within ten-days of the effective date of the change. In order to supply DMH with any changes in your contact information, a copy of the Contractor Address Form has been attached to this bulletin. Please be sure to completely fill out the Contractor Address Form in its entirety, particularly the **personal** e-mail address of the **rendering provider**. As mentioned in Provider Bulletin, 4th edition, Issue 3, "network providers are required to supply an email address to the Los Angeles County Department of Mental Health." E-mail will soon be the method used to contact providers of any modifications the department plans to implement and/or to keep providers apprized of anything that may affect their ability to provide specialty mental health services.

Additional information regarding the Contractor Address Form is attached (Attachment C). After completing the form, please fax it to (213) 381-7092 and mail it to the address listed below:

Contracts Development and Administration Division
Attn: Managed Care Section
550 South Vermont Avenue, 5th Floor
Los Angeles, CA 90020

If you have any questions or need additional information, please contact the Provider Relations Unit at (213) 738-3311.

NEW REQUIREMENT – 9 DIGIT ZIP CODES

Please note: Due to the implementation of HIPAA V5010 guidelines, it is **mandatory** that you submit your 9-digit zip code. Please submit your 9-digit zip codes for all your locations (Mailing, Bill-To/Pay-To, and Service) along with your name, provider number and National Provider Identifier (NPI) via e-mail to: FFS2@dmh.lacounty.gov.

If you have any questions or need additional information, please contact the Provider Relations Unit at (213) 738-3311.

Attachment A

COUNTY OF LOS ANGELES

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Director

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: (213) 738-2814
Fax: (213) 351-2495

July 12, 2011

To: Group Provider Applicant

Thank you for applying to become a group provider in the County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP). In order to enroll as a group provider and receive reimbursement for specialty mental health services provided to Medi-Cal beneficiaries, the legally authorized official of your group must sign a Group Provider Contract with the LMHP.

Please provide the information requested below:

Name of Official: _____

Mailing Address: _____

Service Location Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Official Group Name: _____

Group Medi-Cal Provider Number: _____ Tax ID: _____

Vendor Number (if already assigned) _____

NPI Number: _____

Please fax or mail the requested information to:

Department of Mental Health
Medi-Cal Professional Services and Authorization Division
550 South Vermont Avenue, Room 703 A
Los Angeles, CA 90020
Fax: (213) 351-2495

You cannot be enrolled in the LMHP as a group provider until we have received the above information and have credentialed the individual providers in your group. If you have any questions please contact the Provider Credentialing Unit at (213) 738-2426.

Sincerely,

Nathaniel Thomas, PhD
Supervisor, Provider Credentialing Unit
Medi-Cal Professional Services and Authorization Division

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR
Managed Care Division

Please return this completed form with the Group Provider Application to:

Department of Mental Health
Managed Care Division
550 South Vermont Avenue, Room 703 A
Los Angeles, CA 90020
Fax: (213) 351-2495

Group Provider Name: _____

Group Medi-Cal Provider No: _____

Address: _____

City/State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Please use this form to add new providers, delete terminated providers or list the individual providers in the group who currently provide Medi-Cal specialty mental health services. Each provider must complete an individual provider application and be credentialed.

Add (A) Delete (D) or Current (C)	Individual Provider Name	9 Digit Provider Number	NPI Number	Effective Date

You may attach a separate sheet to list additional provider names

ADDITIONAL INFORMATION CONTRACTOR ADDRESS FORM

PROVIDER #'s are primary locations where the services are provided. Please ensure the correct Provider Number(s) is/are reflected in this Address Form.

THE PAY TO ADDRESS is/are the address that will be used **FOR REIMBURSEMENT. If you receive reimbursement at more than one location, please indicate in writing by placing a checkmark in the proper pay to address, which corresponds with the correct Provider Number(s).**

USE THIS FORM IF YOU HAVE A CHANGE OF ADDRESS

Complete this form and return to the address printed in front of the form. If you have several provider #'s, ensure that the correct number(s) is/are included with the change of address. Be extra careful to ensure the correct Provider Number(s) is/are on this form.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
CONTRACTOR ADDRESS FORM

☐ New
☐ Change of Address

Contractor: _____

Private Residence *NOT FOR PUBLICATION* (UNLESS IT IS THE ONLY ADDRESS ON FILE)

A. ☐ PAY TO ADDRESS ☐ MAILING ADDRESS **PROVIDER #:**

_____
_____
_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

Vendor #: **Email:**

Office Service Location (published for referrals)

B. ☐ PAY TO ADDRESS ☐ MAILING ADDRESS **PROVIDER #**

_____
_____
_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

Email:

Other Service Location (published for referrals)

C. ☐ PAY TO ADDRESS ☐ MAILING ADDRESS **PROVIDER #**

_____
_____
_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

Email:

Other Service Location (published for referrals)

D. ☐ PAY TO ADDRESS ☐ MAILING ADDRESS **PROVIDER #**

_____
_____
_____

Contact Person _____

Telephone No. ( ) _____ **Fax No.** ( ) _____

Please check appropriate **Pay to Address** (for reimbursement) and only one **Mailing Address**.

Return form with Agreement to Contracts Development and Administration Division, ATTN: Managed Care Section, 550 S. Vermont, 5th Floor, Los Angeles, CA 90020. This form is also to be used when reporting a change of address, which can be faxed to (213) 381-7092.

SIGNATURE: _____ DATE: _____